January 12, 2015

Network Adequacy Model Review Subgroup
National Association of Insurance Commissioners’
1100 Walnut Street,
Suite 1500
Kansas City, MO 64106-2197

RE: Revisions to the Managed Care Network Adequacy Model Act (#74)

On behalf of the Alliance of Dedicated Cancer Centers (ADCC), I am writing to submit draft language for your consideration during the NAIC’s ongoing review of the Managed Care Network Adequacy Model Act (#74). Our member institutions, which have a singular focus on cancer, play a pivotal role in the nation’s cancer program to improve the prevention, detection, diagnosis, and treatment of cancer.

We previously submitted a comment letter to NAIC that outlined our request that NAIC ensure that health plans include at least one National Cancer Institute (NCI)-designated cancer center in its network. As you know, cancer is not just one disease—it’s hundreds. In determining whether a “sufficient number and type” of cancer care providers are included in a network to ensure that “all services will be accessible to consumers without unreasonable delay,” ¹ we urge NAIC to consider that only NCI-designated cancer centers have the expertise and capacity to treat certain of these illnesses. The experience of our Centers—which generally has been that our institutions are being excluded from many networks—has deprived many patients of potentially life-saving treatments.

As you may be aware, in its 2015 and 2016 Letters to Issuers in the Federally Facilitated Marketplaces, CMS acknowledged that insufficient inclusion of oncology providers in networks has historically raised network adequacy concerns, and we have encouraged the agency to focus on this problem in its certification decisions. ² Cancer is life-threatening and typically requires immediate action once it is discovered in order for a patient to receive necessary therapy. Delayed treatment, which often results if patients have to go out of network, could seriously impact an individual’s likelihood of survival or ability to regain functional status.

¹ 45 C.F.R. § 156.230(a)(2).
The attached language approaches this problem from several angles. The first, as mentioned above, is requiring that every health plan include a NCI-designated cancer center (Section 5(D)). We believe that this mitigates insurer concern with adverse selection—if every health plan includes at least one NCI-designated cancer center, then no one insurer will disproportionately attract patients who receive a cancer diagnosis.

The second provision supports allowing patients who are suffering from life-threatening illnesses to have access to out-of-network specialists at the same cost-sharing amounts as in-network providers (provided there is no adequate in-network alternative, as determined by an independent review organization) (Section 5(E)). As you are aware, one of the reasons in-network status is critical is that, while requirements have been put in place to limit cost-sharing for patients using in-network providers, there are no limitations on such benefits for out-of-network providers. Because cancer is a chronic illness that is costly to treat, having no limit on out-of-pocket costs is a significant barrier to patient care. Therefore, if insurers continue to restrict the number and type of in-network providers and make it difficult for patients to seek care out of network, the ACA goals of expanding and improving access are thwarted.

The third provision requires that, in tiered networks, the lowest-cost tier include a sufficient number of specialty providers, including NCI-designated cancer centers and children’s hospitals (Section 5(F)).

We appreciate the challenges inherent in developing state policies that balance the concerns of all stakeholders. We are committed to participating in the dialogue throughout this process and continue to analyze ways to ensure that patients have access to comprehensive, high quality, affordable health care. One additional option we are exploring is whether it may be feasible to establish a risk adjustment program, either at the federal or state level, that is modeled on the federal reinsurance program that is expiring in 2016. The goal of this program would be to encourage insurers to contract with a broad range of primary and specialty providers by protecting against exorbitant losses incurred for patients, including cancer patients, whose costs exceed a certain threshold.

Prior to the ACA, patients were denied access to care based on pre-existing condition exclusions and lifetime and annual benefit limits. As these practices have now been extinguished, we encourage federal and state agencies to prevent network exclusions from having the same result.

We look forward to working with the NAIC on these issues and we thank you for your consideration of our request. Please contact Jorge Lopez (202) 887-4128 or Blair Cantfil (202) 887-4452 if you have any questions or require additional information.

Sincerely,

R. Donald Leedy
Executive Director
Alliance of Dedicated Cancer Centers